



## **Health Systems and Structural Change**

*Address by the National Chief to the Health Council of Canada*

Chateau Laurier, Ottawa ON

2pm

November 10, 2008

Welcome everyone. Thank you to the Health Council of Canada for the invitation to speak here today. I note the good work you have done in supporting First Nations on our health care needs and priorities. Meegwetch!

Let me start by bringing a wider lens to our focus on health care reform and First Nations health. Articles 21, 23 and 24 of the *UN Declaration on the Rights of Indigenous Peoples*<sup>1</sup> focus on the right of Indigenous Peoples to the improvement of our economic and social conditions which includes health.

In particular, Article 23 states “Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programs affecting them and, as far as possible, to administer such programs through their own institutions.”

These rights outlined in the *UN Declaration* serve as best practices to which the Government of Canada should aspire. Indigenous peoples all over the world face serious quality of life and health disadvantages and this was recently acknowledged by the latest World Health Organization report.

This past summer, the World Health Organization released a report entitled “Closing the gap in a generation: Health equity through action on the social determinants of health”<sup>2</sup>

The three main recommendations of the report are particularly applicable for healthcare and First Nations in Canada. Among the recommendations, the report states: “Inequity in the conditions of daily living is shaped by deeper social structures and processes. The inequity is systematic, produced by social norms, policies, and practices that tolerate or actually promote unfair distribution of, and access to, power, wealth, and other necessary social resources.”<sup>3</sup>

Our challenge is to enlist the help of this Government to work with us to effectively address the challenges and issues that exist in First Nation communities and which continue to impede and suppress First Nation citizens.

The WHO report also notes that unsafe drinking water, access to housing, high suicide rates and the inequitable distribution of power, money and resources directly impacts life expectancy. We have been calling on the Government to address these and other health determinants the WHO report accounts for the health and social justice gap.

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<sup>1</sup> UNGA Res. A/RES/61/295, 13 September 2007, Annex.

<sup>2</sup> Commission on Social Determinants of Health (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.

<sup>3</sup> Closing the Gap, 10.

First Nations have been facing these challenges for too long. We hope that the international spotlight on the very same issues that plague First Nations will encourage a change in Government response. It is in this spirit that I offer my address to you today.

Since the 2003 Accord on Health Renewal, we have made some progress. Nevertheless, as the WHO report also acknowledged, serious gaps remain between the health of First Nations and non-Indigenous Canadians.

We can make influential changes and improvements for First Nations in the area of health systems and structures and this will require the commitment by all levels of government, including inclusion of First Nations governments.

We already know through the Romanow Report, the Kirby report and a number of reports by the Health Council of Canada: Health systems are not working together, and may even be a barrier to health access in some cases.

Last week, a study in Canadian Medical Association Journal asked: Do First Nations receive the same quality of health care as other Canadians?<sup>4</sup>

In answering this question, it examined two aspects of treatment for kidney disease. They concluded that First Nations patients are not receiving the same quality of health care as other Canadians.

When we look at the response to TB among First Nations, we see another failure of Health Canada and the provincial Public Health Unit to mobilize effective delivery of health care to First Nations. In a recent TB outbreak case in an Innu community in northern Quebec, there seems to be a lack of coordination and experience for both levels to provide expertise and additional human resources to health emergencies in First Nation communities.

To start, improved communication between federal (First Nations and Inuit Health Branch of Health Canada) and provincial/territorial health would improve the delivery of coordinated health services to communities and patients.

The need for the five objectives the AFN has advocated for in all our health-related work is paramount.

**First**, these examples speak to the need for comprehensive plans to deal with health emergencies which includes the availability of adequate and timely medical services.

**Second**, we need to improve the e-health system to share information in health emergencies, for public health surveillance and healthcare access for First Nations.

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<sup>4</sup> Gao, Song et al., (4 Nov, 2008). "Access to health care among status Aboriginal people with chronic kidney disease", *Canadian Association of Medicine Journal*, Vol. 179(10):1007-12.

In terms of caring for illnesses like diabetes, kidney disease and cancer, all of which are demonstrably higher among First Nations populations, I believe First Nations could benefit from a comprehensive video teleconference system that would allow a physician to review the blood work and blood pressure taken by the community nurse and discuss management of the patients without requiring travel by either the specialist or the patient.

**Third**, we need to see policy changes which include the setting of targets and goals, cooperation between systems and access to specialists.

**Fourth**, communication and care between on-reserve and off-reserve must be seamless to prevent either duplication of services as well as preventing patients from falling through the cracks.

**Finally**, First Nations be involved in the design of systems, and policies to ensure they meet the unique and changing needs of our communities.

As we have learned from the Romanow<sup>5</sup> and Kirby<sup>6</sup> reports, Health Council studies, and real-life situations in our communities: **In order to improve health care outcomes we must have better collaboration between First Nations, federal, provincial, and community experts and other health professionals.**

Regular meetings between these respective partners for the development and implementation of comprehensive plans to deal with health care are essential to provided integrated, coherent, effective and responsive health care for First Nations.

The AFN is working to address these cross-jurisdictional issues. For example, the AFN has worked closely with Health Canada to develop a Policy Framework on Tripartite Health Agreements that takes a systems-change approach aimed at addressing gaps in services.

We believe that where it is implemented we will see seamless care for patients who must seek treatment from provinces/territories, and that it will also improving communications between provincial, federal and First Nations health systems.

The **Tripartite Policy** outlines the need for **agreements** that create an equal partnership between First Nations, federal and provincial/territorial governments in planning, policy and interventions regarding First Nations health.

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<sup>5</sup> Romanow, R. et al. (2002). Commission on the Future of Health Care in Canada. Final Report. Ottawa: Health Canada.

<sup>6</sup> *The Health of Canadians – The Federal Role, Final Report. Volume Six: Recommendations for Reform.* (2002) The Standing Senate Committee on Social Affairs, Science and Technology.

The BC Tripartite Health Plan is one example of a tripartite approach as well as the Saskatchewan Health MOU which was signed last month.

Both will make fundamental changes to the way health is funded and provided for First Nations, by allowing First Nations to become a full **partner** with provincial/territorial and federal governments, **sharing the health decision-making, and accountability.**

There are also many community-based examples across Canada.

For example: In northern Saskatchewan, the Athabasca Health Authority is a fully integrated health system. First Nations and the regional health authority joined together to create a seamless health system. Weenebayco in Northern Ontario, and Norway House in Manitoba, are two more regions that are working towards a fully integrated health system.

Some collaboration or integration projects are smaller scale, focussed on a pressing issue faced in the community. For example, in Nova Scotia a collaboration project on mental health is allowing First Nations and the regional health authority to work together with mental health workers.

This is improving the cultural competence of non-Aboriginal health workers, by improving their knowledge of specific mental health issues which may affect clients, such as trauma related to residential schools.

This example, with a number of others, is funded by **Health Canada's Aboriginal Health Transition Fund**. This is a very positive example of how Health Canada is investing in innovative approaches to First Nations health.

Over the next year, I look forward to working with the new Minister of Health to support more communities and regional health authorities in this work.

We look forward to sharing these successes at the next First Ministers Meeting on Aboriginal health, which I hope the Prime Minister will call soon, so that we can work to advance what steps must be taken to improve health services and other factors related to overall health for First Nations. This meeting is important so we can urgently tackle and close the health and social justice gap between Indigenous people and non-Indigenous people which was referred to in the WHO report.

I will now identify some of these next steps here.

As you know, Health Canada provides health services and funding for health services, for First Nations. Federalism or regionalization of health care has led to a patchwork of delivery, programming, services and outcomes across the country in the area of First Nations health.

The key is to move health services closer to the people who need them so they can receive direct, effective and responsive health systems.

Regional health authorities are under pressure, and too often First Nations are not seen as a priority. As we know, we can't afford to let this happen considering First Nations are at higher risk for many illnesses and diseases. As a basic social justice issue, we can't accept as a country that our mothers-to-be, our newborns and our young children are not able to receive adequate maternal, pre- and post-natal and paediatric care. This is unacceptable for our children and our families.

However, given so many regional health authorities, accountability to improve First Nations health is unclear. In many respects, First Nations health is much like a political hot potato, no one wants to touch it.

We must ensure that Regional Health Authorities include First Nations on their boards and in their decision-making processes. Regional Health Authorities must also be accountable to First Nations as well as the province/territory.

Second, provinces/territories should have a First Nations advocate at a high level. For example, in April 2007, the province of BC made the ground-breaking decision to appoint Dr. Evan Adams as the Aboriginal Physician Advisor to the Ministry of Health. Dr. Adams has the specific responsibility for monitoring and reporting on the health of Aboriginal people in British Columbia and tracking progress against performance measures in the First Nations Health Plan.

With his combined expertise of western medicine and traditional health practices, he also demonstrates the cultural knowledge needed to navigate health policy and interventions in First Nations communities – for example in regards to vaccination –where we know there can be gaps in both understanding and values between traditional and western medicine.

These measures would allow First Nations, regional and provincial health systems to collaborate and learn from each other. It can also lead to policy and program innovation. It also allows for existing plans, agreements, policies and procedures to be improved and updated reflecting the changing needs and health priorities of First Nations communities.

However, all of this discussion about jurisdictional muddle is secondary, when we consider that First Nations are worse off than non-Indigenous Canadians insofar as access to primary health care is concerned.

The issue of scarce human resources is shared by all health jurisdictions and shared by all Canadians. Finding a family doctor is difficult in many parts of the country, including here in Ottawa. However, in First Nations communities 1 in 5 First Nations adults cannot access a doctor or a nurse, and 1 in 3 First Nations patients encounter extremely long wait times more than the national average.

First Nations are affected by scarce health human resources in two additional ways:

First, we do not receive equitable funding to pay the salaries of health human resources. For example, a nurse working for a First Nation earns on average 20% less than a nurse who works for Health Canada.

This is because Health Canada does not budget for the real costs of health human resources for First Nations, and there is no support to upkeep their education or accreditation.

So we have the predictable difficulties in recruitment and retention.

We also have fewer First Nations health workers who are trained in areas such as home care workers, bio-technicians, pharmacists, health policy researchers, and in other related areas.

Much like the WHO report suggests, inequity in funding is a serious barrier in achieving effective health outcomes and is a serious social and health determinant. First Nations deserve and require equity in health human resources. We deserve similar quality trained health professionals and para-professionals. And now, after decades of health inequity, it is difficult to put a number on the cost to resolve this issue.

It will take partnerships to address the low number of trained First Nations health workers, from post-secondary health education programs, to the health professional and accreditation bodies.

It will take the combined advocacy of all of our partners to influence the federal government that this is a key lever to address First Nations health.

However, we are making some progress. We are working on a Competency Framework for First Nations Health Managers that will lead to increased skills and expertise. The AFN is hosting a national conference in January and we would most welcome the attendance of a representative from the Health Council.

More and more First Nations youth are going to university and college. The measure of a health program's success in recruiting and graduating First Nations students is affected by the number of First Nations teachers. The long-term goal will be achieved when we have a proportional number of First Nations educators and professors and administrators in health education programs.

The second issue facing First Nation citizens and communities in health human resources is **cultural competency**. Of course we are not saying that all health care providers must be First Nations, but consistent with just and good human rights practices, non-Aboriginal health providers should be culturally competent and offer culturally safe services.

However, why is cultural competency important when we also face dire shortages of diagnostic imaging facilities, access to family doctors and safe birthing units?

It is important because the lack of cultural competence may be one an important barrier which prevents a First Nation patient from going to get that early cancer test or seeking assistance with nutrition and other preventative measures to ward of diabetes and other health care concerns.

It is important because First Nations culture is so closely linked with health. How we see the world, how we relate to one another, our food, language, our spirituality, and our environment is fundamentally tied into our well-being. It is tied to who we are as First Nations. So culturally sensitive health systems can bring down some of the barriers to health care for First Nations in Canada.

The Indigenous Physicians Association of Canada partnered with the Association of Faculties of Medicine in Canada, and completed the first ever Cultural Competency Standard, for doctors.

Once this is fully implemented, every doctor in training will receive training on First Nations, Inuit and Métis cultures, and also be tested before they can practice in Canada.

This is a groundbreaking change and it involved a good deal of work to make this happen.

Finally, the issue of fiscal sustainability of First Nations health care is another barrier to adequate health care for First Nations. Provinces and territories receive the escalator clause for health funding of about 6 to 7% per year.

This is a point of contention for provinces and territories as health expenditures continue to increase well beyond the cost of living with pharmaceuticals and other pressures.

It is not surprising to hear that First Nations healthcare is affected due to the 3% cap in health funding. First Nations receive only 3% per year for very similar health costs, such as nursing stations, health centres, technology, and capital maintenance.

As a result, health infrastructure is severely under-maintained. There are health centres that have mould and other health contaminants and there are communities without basic health equipment such as computers and diagnostic tools.

This is an entirely predictable problem, and now will cost so much more to resolve. This problem could have been prevented with proper planning and considerations for the requirements and needs of First Nations communities and citizens.

Some communities have taken innovative approaches to getting around the cap in funding for health. I challenged the corporate sector to partner with us, to address some of these issues.

For example, Kawacatoose near Saskatoon negotiated a public-private-partnership with Siemens Canada, and together they are building a new health centre in Saskatoon with an MRI that will run on a cost-recovery basis. File Hills Qu'appelle Hospital negotiated with the regional health authority to receive provincial funding and serve all people from their service area. These are just two examples of partnerships and innovations.

We are also reaching out to build new partnerships. For instance, on November 13 in Toronto, the AFN is co-hosting an international forum on indigenous tuberculosis (TB). People will come from Australia, Micronesia, South America, to share the stories about TB and successes in eradicating this preventable disease in indigenous communities.

We are not sitting back and waiting. We are initiating action with our partners.

So on that note, I ask your help on a research question. The Non-insured Health Benefits Program is a national program out of Health Canada. Like any other resident, First Nations access provincial and territorial insured services. However, there are a number of health-related goods and services that are not insured by provinces and territories or by other private insurance plans. To support First Nations people and Inuit in reaching an overall health status that is comparable with other Canadians, Health Canada's Non-Insured Health Benefits (NIHB) Program provides coverage for a limited range of these goods and services when they are not insured elsewhere.

We think this program in some regions does not provide equivalent services, but we do not have the resources to compare this program and analyse the data. I ask you to consider this kind of research work to ascertain this important data.

I also ask you to continue to critique what various governments are doing for First Nations health. This is an important check to ensure that they follow through on their commitments. First Nations look for your support to close the gap in health, to receive equitable health services, and to assist our efforts in improving the lives and well-being of our children, families and communities.

I close with a quote from the latest WHO report: "In the more immediate future, higher levels of better-coordinated aid...applied to poverty reduction through a social determinants of health framework, are a matter both of life and death and of global justice".

Thank you all and I look forward to your questions.